

Toward integrated medical resource policies for Canada: 4. Graduates of foreign medical schools

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This is the fourth article in a series based on the report *Toward Integrated Medical Resource Policies for Canada*,* prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.¹⁻³ The preceding articles summarized stakeholders' views of problems in the physician resources sector,⁴ identified 11 themes running through the report and elaborated on four of the main ones.^{5,6} This article is the first to focus on a particular policy issue: graduates of foreign medical schools.

A significant proportion of physicians newly registered each year are graduates of medical schools outside Canada, and this proportion varies considerably across the provinces.⁷ Entry of these physicians into the country and their dispersion into training or practice settings are the responsibility of no single body. As a substantial source (potential and actual) of physician supply they represent a policy "flash-point." However, "they" connotes homogeneity, an implication that is both unhelpful and misleading. We attempt to disaggregate and demystify the "they" by sketching out the major portals and purposes of entry and the nature of the problems for Canadian physician resource management represented by external sources of supply.

These problems and, indeed, many of the sug-

gested solutions have been around for a long time, which reflects their complexity and the fact that this issue, perhaps more than any other in physician resource policy, is characterized by fragmented jurisdiction and a remarkable lack of coordination. It is, perhaps, the policy area on which there is the most agreement as to the nature of the problems⁴ and the least on how to solve them.

What's behind the label?

It would be misleading to refer to the "problem of graduates of foreign medical schools," partly because historically these physicians have represented important solutions to Canadian physician resource supply problems and partly because included under this label are many different groups presenting different types of policy challenge. The groups include the following:

1. Canadians who would be (or are) accepted by a Canadian medical school but who decide to pursue training elsewhere.
2. Canadians who are unsuccessful applicants to Canadian medical schools but who fulfill the undergraduate medical training requirements of a school accredited by the Liaison Committee on Medical Education (LCME) (i.e., in the United States).
3. Canadians who are unsuccessful applicants to Canadian medical schools but who complete undergraduate medical training at schools other than those accredited by the LCME.
4. "Visa physicians" who are recruited into Canada to meet particular needs (e.g., those of rural areas or for urban subspecialties).

*The full report (in two volumes) is available for \$75 (including postage and GST) from Barbara Moore, Centre for Health Services and Policy Research, University of British Columbia, at the reprint requests address, or fax (604) 822-5690, or from Lynda Marsh, Centre for Health Economics and Policy Analysis, McMaster University, Rm. 3H26, Health Sciences Centre, 1200 Main St. W, Hamilton, ON L8N 3Z5, or fax (416) 546-5211.

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5. Visa physicians who are recruited into Canada to establish or enhance highly specialized tertiary care service and training capacity of academic medical centres.

6. Graduates who enter Canada as refugees or who immigrate to Canada on the sponsorship of relatives or who otherwise meet immigration requirements.

7. "Visa trainees" who are recruited into postgraduate training positions funded through Canadian sources (i.e., positions intended to meet Canadian needs for service or to meet the needs of training programs).

8. Visa trainees who enter postgraduate training positions funded by the countries from which the trainees originate (i.e., positions intended to meet foreign service needs through training in Canada).

Physicians from each of these categories can be found practising in Canada today, but the probability of their achieving full registration status with a provincial licensing authority varies dramatically across the eight categories and 10 provinces and 2 territories.

The nature of the problem

Why are physicians who are trained abroad and immigrate or are recruited to Canada viewed largely as a problem rather than a resource? After all, many physicians practising in Canada today have been trained abroad, and many enter Canada to meet particular training program, specialty and geographic needs. Indeed, they are often seen as the only available way to meet those needs. They all enter without Canadian taxpayers having had to foot their educational costs. Yet they are — and have been for many years — widely maligned.⁸ We believe that two fundamental generic issues underlie this view: the quality of the medical training that such graduates have received and their contribution to overall physician supply.

The quality of training appears to be becoming less of a concern, largely because mechanisms are being established to evaluate and upgrade the clinical skills of many graduates of foreign medical schools (primarily those in categories 3 and 6) before licensure.⁹ Those who have not graduated from a program accredited by the Canadian Association of Colleges of Medical Education and the LCMF must pass the Medical Council of Canada (MCC) evaluating examination to be eligible to sit part 1 of the MCC qualifying examination. Furthermore, the qualifying examination now consists of two parts, the second intended to test clinical competence; eligibility for part 2 includes successful completion of part 1 plus at least 12 months of postgraduate training. In addition, the provincial licensing author-

ity must judge the postgraduate training to be acceptable before it will issue a licence to practise. To provide further mechanisms for evaluating clinical skills and to offer limited postgraduate training opportunities for category 3 and 6 graduates, designated preinternship training and evaluation positions have been funded in a number of provinces. Issues of quality of training remain, but there are relatively direct ways to address them. Our sense is that implications for physician supply are the dominant policy issues, and so we devote the remainder of the article to that aspect.

In a policy environment in which all Western industrialized countries are increasingly concerned by precipitous declines over the past few decades in population:physician ratios^{10,11} immigration and off-shore training are "floating variables." For example, although graduates in categories 4, 5 and 7 enter Canada to meet specific Canadian needs, recruitment decisions are made by several agencies and institutions, whose degree of coordination varies across provinces and territories. Experience suggests that once initial visas expire subsequent stays are not subject to the same conditions and controls, and thus many of these physicians become a part of the permanent Canadian physician supply even though they may no longer be meeting the needs for which they were originally recruited.

However, Canada's health care sector is not solely responsible for this lack of coordination. Control over entry into the *country* of categories 1, 2, 3, and 6 is outside the purview of those responsible for Canadian health care policy (as it should be), but control over entry into *medical practice* is not. For those in the remaining categories, entry into Canada *and* entry into practice are, or should be, legitimate targets of health care policy.

The problems lie largely with categories 4, 6, 7 and 8, of which 4, 7 and 8 are problems only because of diverse federal and provincial "holes" in routes to unrestricted licensure and settlement in Canada. Categories 7 and 8 are particularly problematic, because these graduates often enter Canada for reasons entirely unrelated to physician supply, mix or distribution policy.* Yet substantial numbers of them eventually become fully licensed permanent residents. Category 4 graduates are deliberately added to Canadian physician supply to meet specific needs, but they often find ways to circumvent the restrictions on their practice mobility, because the

*Sometimes funded positions representing future needs are not fully subscribed by Canadian students, but often such positions go begging because their numbers do not reflect Canadian practice requirements. A major policy task will be to rationalize the number of positions and the funding of postgraduate training, part of which will involve separating these two types of situation in which the supply of positions exceeds student demand.

restrictions are not adequately enforced (or enforceable) or because the graduates are given the opportunity to stay in Canada long enough to become eligible for permanent resident status.⁷

With regard to category 6 graduates particularly, the challenge is to develop mechanisms by which their skills will be used to the maximum health benefit of Canadians, subject to the overriding objectives of physician resource policy. The increasing number of these graduates who seek postgraduate training in the United States, expecting entry to practice on return, should be a matter of considerable urgency.⁷ They are granted US training visas on the strength of a letter from the Department of National Health and Welfare testifying to Canada's need for the skills to be acquired. In 1990, the Federal/Provincial/Territorial Conference of Deputy Ministers of Health decided that candidates applying for this letter who are neither enrolled in a Canadian postgraduate training program nor licensed to practise in Canada must provide documented evidence of prearranged employment or a return-in-service commitment in Canada. The department will now issue the necessary letter only if the relevant provincial or territorial ministry of health has approved the employment or return-in-service arrangement (Lourdes Flor: personal communication, 1992). The effectiveness of this new policy will bear careful monitoring over the next few years.

Canada will continue to receive large numbers of graduates of foreign medical schools for whom there are, at present, very few routes to licensure or certification in Canada, yet at the same time Canada continues to recruit large numbers of postgraduate trainees and visa physicians. It seems all the more remarkable that the health care sector does not and will not have control over the entry of "nonselected" physicians yet exercises (at least collectively) complete control over "selected" trainees and visa physicians. One can only conclude that the former enter Canada without the qualifications necessary to meet the clinical or educational standards associated with the positions filled by the latter. Unfortunately, once those selected arrive in Canada it seems that much less can be done to control their eventual entry into mainstream, unrestricted medical practice. These considerations suggest some rather obvious areas for policy attention.

The creation of unlimited opportunities for category 6 graduates to enter clinical practice in Canada is not, however, a desirable policy, simply because the overriding consideration must be Canada's requirements for and decisions about the funding of clinical services within a publicly supported system. On the other hand, there may be substantial opportunities to take advantage of trade-offs among categories 4 to 8.

The recruitment of graduates of foreign medical schools has widespread effects on physician resource policy. As long as these graduates continue to enter practice through selected entry into the country and are seen as solutions to problems at either the training or the practice stage, Canadian policy will not need to deal directly with the fundamental reasons for their recruitment. We have been allowed to avoid addressing the development of incentives that would result in Canadian rather than imported solutions. Reducing Canadian reliance on immigration and offshore training, particularly through categories 4, 7 and 8, requires policies that address directly the underlying causes of the problems (e.g., geographic maldistribution, size and mix of residency programs) to which these sources of training are a solution. The significance of this policy interdependence and of the temporal ordering of the policy initiatives should not be underestimated. It will be practically and politically almost impossible (and in many cases undesirable) to impose more stringent controls on the selected entry of graduates if rural areas continue to experience supply problems and if hospitals have difficulty recruiting Canadian subspecialists for new programs already approved and funded by provincial ministries of health. As long as such needs are unmet by Canadian graduates we will not see a foreign-graduate policy with teeth.

In addition, selected entry of graduates from overseas creates problems in domestic training capacity policy. Reducing the number of undergraduate medical training positions in Canadian schools without reducing reliance on offshore training will not achieve one of the key objectives of domestic training policy — to stabilize or reduce the overall physician:population ratio. The same supply problems would exist, but there would be a much higher proportion of graduates of foreign medical schools.

The potential pool of highly qualified graduates from overseas is going to increase, not decrease, for the foreseeable future. Unemployed physicians are an accepted feature in many countries.^{12,13} Virtually all Western industrialized nations continue to train physicians in far greater numbers than can be justified by the needs of their populations. Furthermore, the state of the world suggests no letup in the flow of refugees into Canada; requests for immigration for family unification and on other grounds seem likely to increase, not decrease. Because the Canadian health care system has and will continue to have no control over this immigration, the pressures from such sources of potential supply will continue to grow.

Getting to a national solution

This is clearly one policy area in which a

national strategy is not only feasible but also probably the only way of achieving the desired objectives, because federal and provincial immigration policy, provincial ministries of health, training establishments and licensing authorities are all involved.

A policy of "no graduates of foreign medical schools" strikes us as neither desirable nor possible. Canadians should continue to be able to reap the benefits of access to graduates of outstanding medical training facilities abroad, and some ethnic communities may be better served (at least in the short term) by physicians of similar ethnic background than by Canadian graduates. Furthermore, physicians from abroad will continue to enter because of overarching immigration policies.

However, Canadians can and should control the rate of entry into clinical practice of such physicians, simply because of the nature of the health care system. Within a publicly funded system elected representatives are responsible to Canadians for using public funds appropriately across a wide variety of public service needs. No Canadian is guaranteed the right to a particular higher education followed by practice in the profession of his or her choosing; new Canadians should be treated similarly and offered opportunities to train for and practise medicine only in accordance with the country's need for their skills. Furthermore, as far as possible visa trainees should be allowed entry for training purposes only, not to fill service requirements of under-subscribed residency programs.

We believe that a three-pronged approach is necessary. (Our recommendations are generally consistent with those in two recent reports^{7,14} that offer a more detailed examination of this issue.) The first and most important set of strategies is not directed at immigration and offshore training but, rather, at reducing Canadian reliance on these sources of supply. Many visa trainees, for example, enter Canada either to fill hospital-based service needs or postgraduate (particularly residency) training positions that Canadians seem uninterested in filling. This requires a serious examination of the number and mix of postgraduate positions funded in Canada and the blurring of education and service provision in teaching hospitals, as well as the development of short-term and long-term incentives to make particular specialty choices more attractive to Canadians — subjects we address in future articles.

Similarly, many visa physicians enter the country to fill needs in locations unattractive to Canadian graduates. Here again the appropriate policy response should be some combination of programs, training exposures and incentives to attract more Canadian physicians to (or at least through) these less well supplied areas, as well as the development of physician alternatives to service those areas. In

this respect, we find that the complaints from some quarters that reducing domestic training positions will simply result in a greater reliance on physicians trained abroad ring hollow. After all, if Canadian students continue to demonstrate a proclivity for practising in areas of relatively ample supply, then one may be forgiven for asking why we should continue to train them.

Other selected foreign-trained physicians may enter to fill highly specialized service requirements; an alternative would be the support of outstanding Canadian graduates to seek the necessary training abroad.

A second component of this policy package must be a more concerted effort to ensure that visa trainees and visa physicians who enter Canada under restricted (either training or geographic) circumstances abide by the conditions of their entry. This will necessarily entail more intensive monitoring and more hard-nosed enforcement. But since these physicians are entering Canada under specific conditions for specific purposes we could neither find nor were we offered in interviews any compelling reasons why such physicians should be permitted to "leak" into overall, geographically unrestricted Canadian physician supply.

Avenues for extending residence (e.g., fellowships for visa trainees) should be seriously examined by all provinces to ensure that the service or training situations involved cannot, in fact, be satisfied in any other manner. As for visa physicians, all entry visas should be time-restricted and renewed only if the original conditions of entry continue to be satisfied (e.g., the physician is continuing to work in a location in which a requirement remains). To the extent that initial visas represent a direct route to landed immigrant status the problem points to the importance of making considerable inroads with the first of the policy avenues. Assuming that other policy initiatives discussed in the remaining articles in this series are successful over time one might expect a dramatic reduction in the need for selected graduates of foreign medical schools.

The third and final strategic policy component is to use more creatively the many foreign graduates entering Canada through nonselected routes. It seems unlikely that physician resource policy will be a major influence on immigration policies affecting refugees in the future. If anything, these people will represent increasing sources of potential physician supply, but they are fundamentally different from the visa category because all of them are, or will become, Canadians.

Here we believe that provinces must be much more creative in finding cost-effective ways of deploying such graduates in situations presently filled by selected visa entrants or by Canadian postgrad-

uate trainees. Some provinces (e.g., Ontario and Quebec) have established distinct postgraduate prelicensure training opportunities, an approach that appears to have survived legal challenge. It has been suggested that nonselected foreign graduates should be provided with equal access to the entire pool of postgraduate training positions in Canada. This argument implies one of two things: either some Canadian-trained postgraduates should be denied the opportunity to complete the training necessary for licensure, or provincial ministries of health should provide sufficient postgraduate funding to allow more graduates of foreign medical schools access to postgraduate training. We fail to find any compelling logic in either argument. Perhaps access to designated prelicensure training streams might be contingent on the provision of limited public service in particular situations after graduation (as is the case in Quebec). The limited prelicensure slots should not be available to anyone who did not declare his or her status as a graduate of a foreign medical school at immigration.

Nonselected foreign graduates might also be employed as, for example, physician assistants (after any necessary upgrading of skills) to satisfy some hospital service requirements currently met by postgraduate trainees in situations in which the number of graduates of those training programs exceeds Canadian needs; such experience might be taken into consideration in any application for prelicensure training. Such options will, of course, require careful consideration of both the costs and the benefits of any skills upgrading, but they strike us as worthy of more attention than they have received to date.

What has not emerged is a national strategic plan for nonselected graduates. The provinces appear to be developing individual approaches with no sense of what the aggregation of approaches might imply for overall supply or for interprovincial distribution. We feel that this is a potentially fruitful area for the development of a national strategy. These graduates are a potential Canadian resource and should not be viewed as a resource or a problem only for the province in which they initially settle. Working collaboratively the provinces should be able to develop an equitable and consistent way of providing training sites and funding that would best satisfy other physician resource policy objectives, such as the correction of geographic imbalances in supply.

Possible options include an interprovincial and territorial funding pool and a process for deciding which provinces or territories will provide the physical training capacity, the training then being funded from this pool. Some of the provinces that seem to have taken the lead in providing such training opportunities (e.g., Ontario and Quebec) are the ones that least need additional physicians entering prac-

tice. Of course, whatever the process governing their entry to practice in Canada, the clinical competence of nonselected graduates of foreign medical schools must be equivalent to that of graduates of Canadian training programs.

National control of entry of selected graduates into permanent physician supply must derive largely from domestic licensing, funding, training and other physician resource policies. Some steps are already being taken, not the least of which was the recent initiative (spearheaded by the MCC) to eliminate enabling certificates, which were providing a means of circumventing prerequisites for provincial licensure.

On the other hand, the recent changes to the MCC conditions for sitting the two-part qualifying examination may make the licentiate of the MCC (LMCC) easier for graduates of foreign medical schools to obtain. In particular, any graduate who has successfully passed the MCC's evaluating examination is entitled to sit part 1 of the qualifying examination, and part 2 may be taken on provision of evidence that 1 year of postgraduate training has been completed at any site listed by the World Health Organization. However, the requirement of taking two separate examinations (particularly for those graduates not yet resident in Canada) and the likely higher failure rate associated with two than with one examination may make the LMCC a more elusive goal for graduates from overseas. At the end of this process, though, it will be up to each provincial medical licensing body to decide whether the postgraduate training of someone with an LMCC is acceptable for licensure. In this respect the 2-year postgraduate training requirement for prelicensure will have a considerable bearing on the future interprovincial portability of licences.¹⁵

With respect to selected visa trainees there are undoubtedly other ways of ensuring that they leave the country after a reasonable period of training. (On this, we would agree with the Federal/Provincial/Territorial Advisory Committee on Health Human Resources¹⁴ that the Department of Employment and Immigration's regional policy of providing a 1-year education-related employment entitlement to visa trainees on completion of their formal training may be counterproductive from a Canadian perspective. At the very least, the department should closely monitor physicians who avail themselves of this option). The establishment of a visa category equivalent to the "J" category in the United States might go some way to improving this situation.

Similar approaches could ensure that visa physicians either return home or continue to practise only under the restricted conditions for which they were granted entry. Options here include the issuing of restricted (and time-limited) licences by provin-

cial licensing authorities or restricted rights of access to provincial medical plans. The successful legal challenge to British Columbia's Bill 41 should not be seen as an impediment to policies designed to enforce written commitments of visa physicians, partly because there is compelling legal opinion suggesting that the judgement in that case was seriously flawed and should not be viewed as binding on other provinces¹⁶ and partly because such policies would not be intended to affect all physicians but, rather, to be an enforcement tool, ensuring that written contracts of visa physicians are upheld.

Such initiatives, however, are made difficult and probably impossible to implement once graduates of foreign medical schools have been in Canada long enough to become legal permanent residents. It is much easier to suggest such policies than to enforce them. Visa trainees may, for example, complete a residency training program and then perhaps a 2-year fellowship, at the end of which they have been in Canada for 6 or 7 years, are highly valued by the institution where they are based and are meeting a regional specialty need. They are probably as close to "immovable objects" as one is likely to find in physician resource policy.

The problems posed by attempting to force those granted temporary visas to leave Canada ought to be a strong motivation to focus on the first of the three strategic components: the reduction of situations "requiring" visa entrants.

In short, the policy options for addressing sources of supply from graduates from overseas should be a package of initiatives that will (a) reduce the need for selected visa entrants through a review of the need for some of the positions presently filled by these graduates and through encouragement of more Canadian graduates to fill situations that are necessary but are currently satisfied by selected visa entrants, (b) monitor and enforce the conditions of entry for selected entrants, and (c) use nonselected (Canadian and permanent resident) graduates from overseas more creatively than has been the case to date and thus further reduce the need for selected entrants.

During interviews and after our report was released we heard repeatedly that immigration and offshore training of physicians are the main problems for Canadian physician resource management, problems that may be impossible to solve. We agree with the former but not the latter, even though a comprehensive and effective strategy has not yet been formulated. At the very least, it seems worth a concerted and nationally coordinated effort, not only for the narrow purpose of solving the "problem" of

immigration and offshore training but also because in that solution lies the key to many of the other physician resource problems plaguing the country. A reduced inflow of selected graduates will be a barometer of progress elsewhere, because it will be unlikely to materialize without such progress.

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References

1. Barer ML, Stoddart GL: *Toward Integrated Medical Resource Policies for Canada*. Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991
2. Idem: *Toward Integrated Medical Resource Policies for Canada: Background Document*, University of British Columbia (HPRU discussion paper 91:6D), Vancouver, and McMaster University (CHEPA working paper 91-7), Hamilton, Ont, 1991
3. Idem: *Toward Integrated Medical Resource Policies for Canada: Appendices*, University of British Columbia (HPRU discussion paper 91:7D), Vancouver, and McMaster University (CHEPA working paper 91-8), Hamilton, Ont, 1991
4. Idem: *Toward integrated medical resource policies for Canada: 1. Background, process and perceived problems*. *Can Med Assoc J* 1992; 146: 347-351
5. Stoddart GL, Barer ML: *Toward integrated medical resource policies for Canada: 2. Promoting change — general themes*. *Can Med Assoc J* 1992; 146: 697-700
6. Idem: *Toward integrated medical resource policies for Canada: 3. Analytic framework for policy development*. *Can Med Assoc J* 1992; 146: 1169-1174
7. *Report of the Joint Working Group on Graduates of Foreign Medical Schools to the Federal/Provincial Advisory Committee on Health Human Resources*, Dept of National Health and Welfare, Ottawa, 1986
8. Evans RG: Does Canada have too many doctors? — Why nobody loves an immigrant physician. *Can Public Policy* 1976; 2: 147-160
9. Brookstone AJ: *Medguide: an Information and Licensure Handbook for Canadian and Foreign Physicians*, Medical Information Services, Richmond, BC, 1992
10. Adams O: Canada: One country among many grappling with MD-oversupply issue. *Can Med Assoc J* 1989; 140: 68-69
11. Viefhues H (ed): *Medical Manpower in the European Community*, Springer-Verlag, New York, 1988
12. Morosini PL: Italy. In Viefhues H (ed): *Medical Manpower in the European Community*, Springer-Verlag, New York, 1988: 147-158
13. Ritsatakis A: Problems related to future medical demography in the European Community. *Ibid*: 205-237
14. Federal/Provincial/Territorial Advisory Committee on Health Human Resources: *Report on Post-MD Clinical Training Positions*, Dept of National Health and Welfare, Ottawa, 1990
15. Brookstone AJ: Process of licensure and exam are separate [C]. *Med Post* 1992; 28 (5): 11
16. Lepofsky MD: A problematic judicial foray into legislative policy-making: *Wilson v. BC Medical Services Commission*. *Can Bar Rev* 1989; 68: 614-629